UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

AMEVIVE (alefacept)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext. and opt._____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY

CRITERIA:

- Severe Chronic Plaque Psoriasis
- Candidate for systemic or photo-therapy
- Lack of other concomitant immunosuppressive agents
- Step therapy which includes trial of Methotrexate, Acitretin (Soriatane) or Methoxsalen, rapid, Oxsoralen-Ultra and Cyclosporin
- Minimum body surface area involvement >10%

INFORMATION:

To be given in clinic setting only. Patients with HMO's (except IHC) will have to make arrangements with their HMO for coverage. Provider will bill with J code 3490 and PA number.

AUTHORIZATION:

Initial authorization is for 12 weekly injections

RE-AUTHORIZATION:

Additional 12 week course may be initiated provided CD4+T lymphocyte counts are within normal range and a minimum of 12 weeks have passed since the previous course of treatment. Maximum annual coverage is 24 weeks.